

Removal of the posterior laryngeal wall; cauterized with 80% of lactic acid. For the next thirty days there was not so much cough, and apparently he was much improved. Up to this time he remained in San Francisco attending to his work, which necessitated his being out a great deal at night. Six weeks after the first operation he had high fever, night-sweats, rapid loss of weight, and a cough that was almost as severe as when he first consulted me. At this time there was decided edema of the aretenoids, which was not interfered with. The patient was sent to the mountains where he could be in the open air the whole twenty-four hours. Returned in one month somewhat improved; occasional night-sweats; was not losing weight; was not gaining; temperature 100° F. The cough seemed to be the only annoying symptom from which he complained; the aretenoids were more edematous than before. I scarified, which gave him relief which lasted for ten days. Returned to the city at the end of thirty days in practically the same physical condition that he was in thirty days before. The edema was considerably increased; it was increased to such an extent that I advised a tracheotomy at once. He had considerable dyspnea and almost complete stenosis. He would not submit to operation, so I told him that I could not continue to treat him if he would not follow my directions. He died some six or eight months later.

Case 2. Female, age 38, married; three healthy children, husband healthy, her family history negative; poor hygienic surroundings. Healthy until one year ago, then she developed a cough and lost weight rapidly; had night-sweats and daily temperature. In about three months was very much improved and gained some weight; did not have night-sweats; no temperature. The cough continued and she began to have pain in the larynx. The pain in the larynx has persisted, and, in fact, has grown more severe in the last month; at times the pain is so severe that she can scarcely swallow. She would like to eat, but will not, because of the intense pain. A decided thickening of the posterior wall with an ulcerating surface was found. This was removed the following day and cauterized by 80% lactic acid. The day after the patient began to eat and has not had a laryngeal symptom since. She gained twenty pounds in four weeks, and from appearances is perfectly well.

Case 3. Male, age 42, clerk by occupation, married, no children, never robust, however was never confined to bed by illness; parents, brothers, sisters and wife healthy. About one year ago had influenza, from which he did not completely recover; it left him emaciated, weak, and with a cough. He had daily temperature; night-sweats occasionally. About six months after his attack of influenza he began to experience pain in the larynx when he coughed; this pain increased gradually for three months until he consulted me. He said that it was so painful for him to swallow that he had not swallowed a thing for five days. Besides this, he had night-sweats, losing weight rapidly. The cough at this time was very persistent, and would prostrate him very much because of the pain induced. Examination—Half of the epiglottis had been destroyed by the tubercular ulceration; otherwise the larynx was reddened. I told the wife what I found, what I proposed to do, and what would happen. They insisted that I should proceed at once, which I did, removing the ulcerating surface of the epiglottis, which included practically the whole of the epiglottis; cauterized with 80% lactic acid. I then gave the patient two glasses of malted milk, which he drank with a relish, saying that he had never tasted anything so good before. In a few days he was taking semi-solid food. In the course of a week he was taking solid food. He began to have some pain about ten days after the primary operation. On very careful examination I discovered a few points of granulation tissue in my former field of operation. They were removed, and their surfaces cauterized by lactic acid. The only annoying symptom that this patient had after the primary operation was the accumulation of mucus in or about the larynx. This was relieved by an alkaline spray. The patient lived sixty days from the time of the first operation. So far as his larynx is concerned, he was perfectly free from all laryngeal symptoms, which no doubt contributed much to the comfort of his remaining days.

Fraud at Medical Examinations.

The Maine board of examiners desires attention to the fact that fraud in taking examinations before state licensing boards is a danger which must not be overlooked. At a recent examination, according to a newspaper clipping sent to the JOURNAL, a certain Dr. Houghton Baxley, of Baltimore, appeared in the place of a man named O'Malley. The fraud was detected and both were arrested. The outcome we do not know. In the report of the West Virginia board for 1903 and 1904, is recounted a similar case, wherein a Dr. Thos. H. Magnus, a professor in the Baltimore University School, appeared for a second course student by the name of David R. Shepler. He was arrested and placed in jail; later he secured bonds in the sum of \$500.00 and subsequently jumped his bail and left for parts unknown.

PARTIAL REDUCTION IN DISLOCATIONS OF THE SHOULDER.

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WHILE partial dislocation of the humerus, as described by Sir Astley Cooper¹, seems a possibility, its existence has been denied by some. Personally I see no reason why such a condition should not exist, for there may be a cessation of the force which has caused the accident when the head of the bone has but partly rent its way through the capsule. We can safely say that it is a rare lesion and the cases which have been reported may be the result of faulty observation; but the same condition as the result of partial or incomplete reduction, which is far more serious because it means so much for the welfare of the patient, is not uncommon.

During the past winter 3 cases of partially reduced shoulder dislocations have presented themselves at my surgical dispensary service in the University of California. These were in men from 38 to 60 years of age who had been treated by different practitioners for forward dislocations at periods of 5 days to 5 weeks before coming to the dispensary. They all complained of limitation of motion and pain upon movements of the affected shoulder.

The head of the bone was in each instance partially within the glenoid cavity. In two the deformity of the injured shoulder was so slight as to be noticed only by careful inspection. As this type of case is important the histories are given in detail: To these I add a fourth case which seems to have been originally a good example of partial dislocation. As I did not see the patient, however, until nearly two months after the accident I cannot be certain upon this point.

Case 1. O. L., a carpenter aged 60 years, had fallen on the right shoulder causing a forward dislocation, 10 days before presenting himself to me. He had received medical attention immediately after the accident. He complained of great pain on all movements involving the shoulder joint. It was found that the position of the arm and forearm was good, the acromio-external-condylar measurements were the same on both sides and there was no swelling about the injured shoulder. There was slight bulging on the affected side, the head of the bone seeming to press forward in its socket. This was brought out by careful comparison with the other shoulder and shown by the increased rotundity of the deltoid upon the injured side when the arms were abducted to a right angle. Reduction was accomplished by means of the Kocher method and a plaster-of-Paris dressing applied. Massage and passive motion were commenced 7 days later and the patient discharged in the third week with full restoration of function.

Case 2. M. K., a laborer aged 38 years, fell down stairs 5 days before coming to the clinic and received a forward dislocation of the left shoulder. An anesthetic had been given and reduction undertaken soon after the injury. He complained of pain on the slightest motion and numbness in his fingers. Flexion was limited to about three-fourths normal amount. Abduction was impossible, but adduction was fairly good. There was slight inward rotation and supination was accomplished with great difficulty. Paralysis of the deltoid was present. The head of the humerus was a finger's breadth below the acromion process and rested upon the edge of the glenoid cavity. Acromio-external-condylar measurement on affected side was 35 cm., while the same measurement upon the opposite side was 34 cm. The patient was given an anesthetic and after several attempts complete reduction was accomplished by Kocher's method and a plaster of Paris bandage applied. Two days later the muscles had somewhat regained their tone and the head of the bone was much nearer the tip of the acromion process. The hand could now be easily lifted to the forehead. The plaster-of-Paris bandage was reapplied and the further progress of the case was without incident. The patient was discharged 10 days later.

Case 3. D. H., aged 50 years, fell on the upper and outer third of the right humerus, sustaining a dislocation, 5 weeks before presenting himself at the clinic. He had received surgical treatment after the injury. I found no limitation of adduction, but abduction was limited to 70°. There was no difference in the acromio-external-condylar measurements. On inspection the muscles of the right arm were found to be somewhat atrophied from disuse. The rotundity of the deltoid was lost and the head of the bone was found to rest somewhat anteriorly in

the glenoid cavity, so that the point of the shoulder on close examination was seen to be slightly more prominent than the other. The patient was given an anesthetic and complete reduction accomplished by means of the Kocher method. The arm was then bandaged securely to the side. This patient was subsequently lost track of and it has been impossible to trace him.

Case 4. O. A., a muscular German, aged 52 years, while intoxicated on the night of Thanksgiving day, was jostled and fell to the sidewalk, striking on the left elbow and shoulder. Next morning he had considerable difficulty in putting on his clothes. Since then the right shoulder joint has been painful, but the patient has been able to move his arm fairly well. When he presented himself at the clinic on January 20th there was great pain on attempting to abduct the humerus above a right angle. The head on the affected side was prominent; there was bulging of the muscles in front and a corresponding depression behind. The parts about the shoulder were not swollen. There was slight atrophy of the deltoid. On palpation the head of the bone was found to rest anteriorly upon the edge of the glenoid cavity. The patient was certain that it had not changed its position since the original injury. An anesthetic was given and forcible motions in all directions, as recommended by Castu² were made with a view to breaking up adhesions. I then tried for a half hour to accomplish reduction by Kocher's and other methods, but failed.

The patient again reported 3 days later and I was surprised to find that he had full range of motion on the affected side. He stated that the day after the attempts at reduction were made he suddenly lifted his arm and felt the head of the bone return into its socket. The point of the shoulder, however, was still somewhat prominent and reduction was not complete. The case was referred to Professor Harry M. Sherman, who advised massage and light exercise. The patient was seen by me on July 19th. He had been very systematic in his massage and his exercises with light dumbbells. He had full range of motion and he stated the joint was much stronger. There was marked crepitation on strong abduction. The humerus was still slightly in advance of its normal position. All movements below height of shoulder gave no pain; movements above height of shoulder gave pain if long continued.

A case of Mercer's somewhat resembles this and an abstract of it is here quoted. Mrs. B., aged 56 years, was thrown from her carriage 7 years before, dislocating her right shoulder. The shoulder was reduced shortly after the accident. When seen by Mercer motion was limited and she could not raise her elbow from her side more than half way to a horizontal position without assistance. Measurement showed no appreciable difference in the size or length of the arm or the size of the shoulder, but the point of the shoulder was prominent in front and flattened behind. I examined the shoulder in November last and it presented the same general appearance. Some 6 weeks previous to this examination, in a sudden and thoughtless effort to raise the arm above the head, the muscles unexpectedly obeyed the will. Since which time she has had perfect use of it, though the deformity still remains. She thinks she felt or heard a snap when the arm went up, but it was followed by no pain, soreness or swelling.

It will thus be seen that complete reduction was accomplished in 3 cases after the limb had been partially reduced by others. It would not be just to say that the incomplete reductions were the fault of the surgeons who first treated the cases, or that the subsequent successes were due to greater sagacity on our part. "At this latter period," writes Sir Astley Cooper¹, "if we detect a dislocation which has been overlooked it is our duty in candor to state to the patient that the difficulty in detecting the nature of the accident is exceedingly diminished by the cessation of inflammation and the absence of tumefaction."

I believe that partial reduction is often overlooked and that it is the greatest cause of the bad results which now and then follow upon uncomplicated shoulder dislocations. Boyer⁵ early made the statement that "ankylosis is never the consequence of luxations of the humerus when they are reduced. The motion of the arm, first impeded by the pain, becomes daily more free and is soon performed with as much facility as before the luxation had taken place."

The most common impediment to complete reduction is probably the interposition of a portion of the capsule. The presence of new tissue in the glenoid cavity is not to be thought of in connection with the cases cited, unless possibly with case 4. Other causes which may enter into the problem are the interposition of the tendon of the biceps and rarely that of the subscapularis. Hamilton⁶, in commenting

on the case of Mercer, believes that this deformity was due to displacement of the long head of the biceps.

It can hardly be claimed that the cases which I have cited were the result of relaxation, an accident which occasionally happens. The relaxations which I have seen have been complete and I can find no reference to partial relaxations in the literature.

REFERENCES.

1. Cooper—Dislocations and Fractures, 3d Lond. Ed., 1824.
2. Castu, M. And.—*Revue de Chirurgie*, Oct. 10, 1888.
3. Mercer—*Buffalo Medical Journal*, April, 1859.
4. Loc. cit.
5. Boyer—Diseases of the Bones, 1805.
6. Hamilton—Fractures and Dislocations.

Note. Since the above was written I have met with one instance of undoubted partial dislocation.

A. J., a muscular man of 40 years, fell on his left shoulder two days before presenting himself at the clinic. When seen by me there was no ecchymosis but it was impossible for him to abduct the arm but a slight distance from the side, and this was accompanied with great pain. On careful palpation the head of the humerus was found to rest slightly forward in the glenoid cavity. The rotundity of the deltoid was slightly less upon the affected side. Reduction was accomplished by the Kocher method, and the patient was able, before he left the clinic, to abduct the arm to its full extent. This was accompanied by slight pain; two days later the movements were normal and without pain.

The California Board of Medical Examiners.

One of the periodical outbursts against the California State Board of Medical Examiners has recently taken place at Los Angeles. A physician who lost two sons in a battle with the board threatens suit on the ground that his boys were "plucked" through malice against the College of Physicians and Surgeons, from which they were graduated in June. It is charged that the president of the board shows a dislike for the name of this institution, and has expressed a determination to prevent any graduate of the College of Physicians and Surgeons of either Los Angeles or San Francisco from receiving a license to practice, though he had to sacrifice other candidates to do so. Another physician charges unfairness, and calls the president a trickster, supporting the charge with several specifications, but this physician also has felt a wound, for he himself failed to pass the examination in bacteriology before the board. Several of the most prominent members of the Los Angeles profession have come to the rescue of the president of the board in just as emphatic language as that used by the disgruntled ones. It must be admitted that the standard set by the California board is a high one, but it should be maintained, for the state is a Mecca of the quacks of Christendom. A review of the questions submitted at any examination shows that they are selected in every branch with remarkable skill, both with a view to fairness and as a test of the knowledge of the applicant. Unfortunately, the president of the board is said to have made a custom of submitting two questions* at the close of each test which are particularly obnoxious to even the best bacteriologists, one requiring the diagnosis of a culture tube, the other the naming of a stained specimen of bacteria, without any information as to the preparation of either, each question counting ten per cent in the final average. Possibly he has been indiscreet in some of his remarks, but the evidence against him comes from unfortunate candidates, many of whom prove themselves incapable of answering the simplest questions in almost any branch.—*Medical Record*, Jan. 13, 1906.

*This we are advised, has been discontinued.